Medical Assistance Administration
Division of Medical Management and Division of Program Support

The Problem: Washington State Medicaid Healthy Options managed care children do not receive the age-appropriate number of well child visits for commonly accepted preventive health care services. Both the number of visits and quality of care (the number of visits meeting a minimum threshold of quality[1]) remain low among managed care children. The table below represents the statewide average, i.e., the percent of children receiving well child visits over the past five years among managed care plans.

Age Categories Reported and Qualifying Well-Child Visits	1998	1999	2000	2001	2002
0 – 18 month olds – reported	46%	58%	62%	66%	63%
0 – 18 month olds - qualifying	18%	33%	32%	37%	34%
3 – 6 year olds – reported	37%	37%	42%	42%	41%
3 – 6 year olds – qualifying	15%	19%	20%	20%	21%
12 – 18 year olds – reported	26%	23%	35%	38%	38%
12 – 18 year olds qualifying	9%	9%	14%	18%	20%

MAA requires health plans to report and collect HEDIS (Health Plan Employer Data Information Set) measures for their enrolled population each year. The HEDIS childhood immunization measure calculates the proportion of children continuously enrolled in the health plan for twelve months prior to their second birthday and who receive age appropriate immunizations by their second birthday. The table below reflects the percent of children receiving age appropriate immunizations. Over time the rate of immunizations have remained relatively flat.

2 Year Old Immunizations – Combo 1[2]	1998	1999	2000	2001	2002
0 – 2 year olds	53.6%	57.9%	52.5%	58.6%	59.9%

Actions Taken to Address the Problem:
A number of activities have been implemented in an effort to improve both well-child care and immunization rates for 2-year old children. Among these are:

- Managed Care Contract Requirements:
  MAA requires health plans to complete a quality improvement initiative if well-child care rates for any age category or 2- year old immunizations are below 60%. Health plans have employed the following interventions to improve care: postcard and telephone reminders to parents, incentives to parents and children such as bicycle helmets, gift certificates, and periodicity schedule mailers to parents; guidelines in provider handbooks and performance incentives to health care providers and clinics.

- Washington State Well-Child Exam Forms:
  These forms were developed collaboratively with the Washington Chapter of the American Academy of Pediatrics, the Department of Health, Head Start/ECEAP staff, health plan staff and many other stakeholder groups as part of a statewide focus on improving well-child care. These forms are free of charge to providers who deliver well-child care to Medicaid clients and have been translated into multiple languages. The forms are unique to each age and include the ages listed below:
  - Infancy – 2-4 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, and 2 years
  - Early childhood – 3 years, 4 years, 5 years, 6 years, 8 years, and 10 years
  - Late childhood – 12 years
  - Adolescence – 14 years, 16 years, 18 years

[1] To be considering a qualifying visit, the following must be evident in the medical record, i.e., documentation of: medical history and physical, height, weight, developmental screen, mental health screen, and anticipatory guidance and education.
[2] Combo 1 includes the following immunizations: 4 DtaP, 3 IPV, 1 MMR, 3 HiB, 3 HepB

Each age-specific document is a two-page, NCR form. The first sheet is for the child's medical record. On the back of the first page includes information about different components of the exam. The second page is given to the family after the exam. The back of the second page provides the family with both parent education and information about the child's growth and development between the current visit and the next anticipated visit. The forms are available in hard copy and can be ordered through MAA. The forms can also be found at the website: www.wa.gov/dshs/dshsforms/forms/eforms.html (the forms start at number 13).

- EPSDT Rate Increase for Foster Care Children:
  As a result of several studies that suggested that children in foster care were not receiving adequate health care services, MAA increased the rate of reimbursement for well-child care (for this population only) in November 2001. MAA has examined the impact of the rate increase and other interventions employed by Children's Administration to improve care for foster children. Baseline and one follow-up measurement are complete. The rates of well-child care have increased and the results are statistically significant.

- EPSDT and Immunization Improvement Team Meetings:
  Facilitated by Diana Larsen-Mills, the team provides a forum for stakeholders to meet and share interventions undertaken by various groups, such as health plans, local health jurisdictions, and Head Start/ECEAP providers to insure children receive well-child examinations and age-appropriate immunizations. One of the products of this team is the Well-Child Exam Forms and collaboration with the Department of Health on the implementation of the statewide immunization registry, Child Profile. The registry tracks immunization status for children and provides educational materials to parents.

- Performance Feedback:
  Employing methods developed by the University of Alabama, MAA provided clinic-specific performance feedback to 80 health clinics in 2001. Achievable Benchmarks of Care (ABC™) are calculated from the best rates among the actual performance of clinics in Washington State. One hundred and one clinics received performance feedback in 2002. (See Attached example). The performance feedback allows clinics to compare themselves against a Washington State benchmark and use for improvement activities.

- Children's Preventive Healthcare Initiative (CPHI):
  MAA allocated a significant portion of its 2003 and 2004 External Quality Review (EQR) [3] funding to improve preventive care for children. In preparation for the improvement activity, EQR contractor OMPRO conducted focus groups with parents of children, foster children, and providers to better understand the barriers to well-child care. A common finding from the focus groups was the issue of access. For parents, concerns included having difficulty getting to the provider, seeing the provider in a timely fashion once they were in the clinic, and inconsistent caregivers. Parents, particularly of three to six year olds often did not understand the value of a well child visit if their child was well. For providers, common issues were reimbursement; one provider suggesting that improved reimbursement would help address access issues.

  A literature review of best practices that improved preventive care was completed in 2002. OMPRO tested several of these interventions at three Vancouver, Washington clinics in December 2002-January, 2003. Several interventions were tested. These included postcard reminders to parents for overdue visits, follow-up phone calls using staff from Columbia United Health Plan for those parents not scheduling a well-child visit, and incentives for adolescents (gift certificate to Fred Meyer). Preliminary results suggest that postcard reminders alone yielded a 13 to 18% increase in parents scheduling their children for a well-child examination. In addition to the interventions above, all three targeted clinics signed up for the Washington State Child Profile Immunization Registry.

  Eleven clinics now participate in a project designed to improve care. Clinic staff received training on quality improvement methods and implemented interventions to improve care. Among the interventions tried include use of clinic information systems to identify children overdue for care and outreach activities such as postcard reminders and telephone calls to bring children in for care. Participants are also learning about different ways to organize care, such as the use of group well-child visits by a clinic with one of the highest rates of well-child care in the state of Washington.

[3] External Quality Review (EQR) is a federal regulatory requirement. State Medicaid managed care programs are required to assess health plan quality management programs, including health plan sponsored quality improvement projects on a yearly basis. In addition, health plans are required to report performance measures, such as the HEDIS immunization measure on a yearly basis. State dollars for EQR activities is federally matched at a 75% level (75 cents on the dollar).

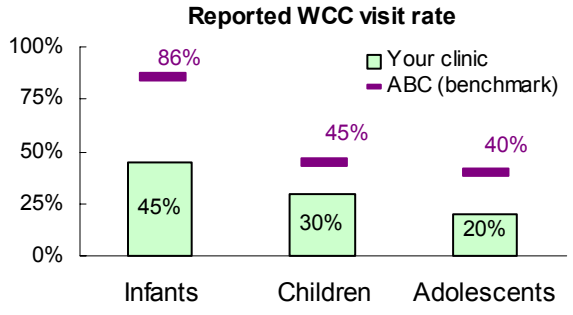
Healthy Options Preventive Healthcare Summary Report

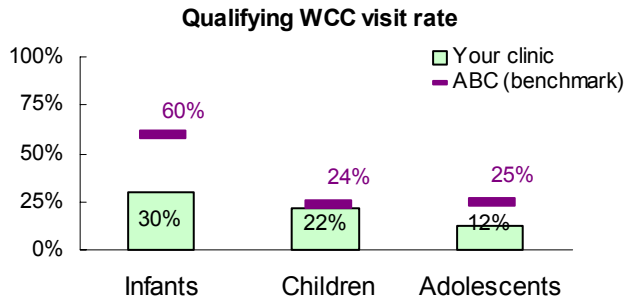
Example Clinic Performance for Year 2001

Washington Medical Assistance Administration (MAA) conducts retrospective reviews of preventive health care delivered to children covered by Medicaid. Medical records for review are selected at random. The tables show the number of records from your clinic in the sample selected for the well-child care (WCC) review and the 2002 MCO HEDIS®[i] childhood immunization review. The charts summarize the preventive healthcare your clinic provided in 2001 to patients in the sample, compared with an Achievable Benchmark of Care (ABC™).[ii] ABCs were calculated from top performance rates of providers who together treated 10% of the clients in the sample. The sample represents 101 Washington clinics/providers.

Preventive health care includes reported and qualifying visits. Reported visits are all visits documented as WCC visits. Qualifying visits are reported visits that have medical record documentation that addresses four required clinical areas—physical exam/health history, developmental assessment, mental health, and health education/anticipatory guidance. The areas most often missed are mental health and anticipatory guidance.

Your clinic's rates/ABC (benchmarks) for WCC visits

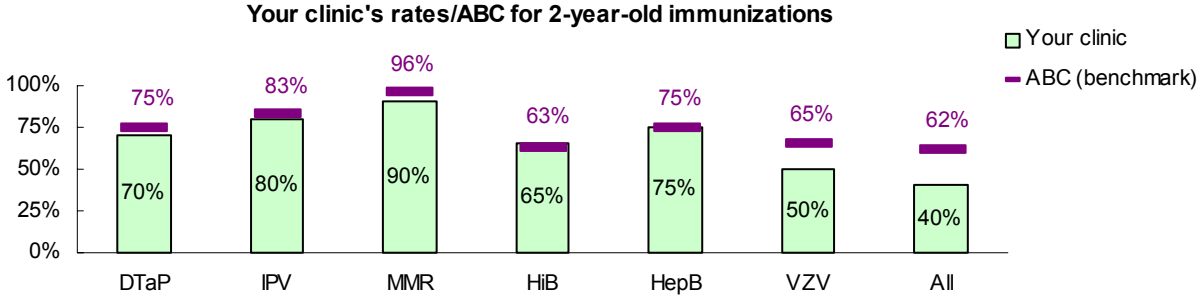




Your clinic's sample size and number of expected, reported, and qualifying visits

Age groups	Sample size	Expected visits	Reported visits	Plus 10%**	Qualifying visits
Infants (0–18 mo)	10	70*	51		27
Children (3–6 yrs)	10	10	5		2
Adolescents (12–20 yrs)	10	10	8		1

*Calculated by multiplying the number of infants by the 7 required infant visits
**Number of reported visits needed to reflect a 10 percentage point increase in reported visit performance rate



Number of patients up to date for 2-year-old immunizations

Sample size	DTaP	IPV	MMR	HiB	HepB	VZV	All
20	14	16	18	13	10	15	10

[i] HEDIS® 2003 Technical Specifications, volume 2; pp 63-67. HEDIS® is a registered trademark of the National Committee for Quality Assurance

[ii] Weissman NW, Allison JJ, Keife CI, et al. Achievable benchmarks of care: the ABC™s of benchmarking. *J Eval Clin Pract* 1999;5(3):269-81.